BILL ANALYSIS

S.B. 418
By: Nelson
Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Issues related to the prompt payment of physicians' claims by insurers have confronted lawmakers since 1997. Texas physicians contend that insurers are slow to pay or refuse to pay for services rendered to insured patients; insurers contend that providers do not provide complete and accurate billing information. Despite passage of state law in 1999 that was intended to accelerate payments to providers, physicians still claim that insurers have been able to avoid prompt payment of claims. In May of 2000, the Texas Department of Insurance adopted rules to implement the new law requiring payment of a "clean claim" within a specified time period. The rules defined a clean claim as one submitted with documentation reasonably necessary for the insurer to process the claim and included a list of elements based on federal claim forms for Medicare. Under those rules, an insurer could request attachments, such as medical records or operative reports, and the amount paid by any other insurer. Despite the statutory changes and new rules, problems relating to the prompt payment of claims persisted. The 77th Legislature enacted H.B. 1862 to further revise prompt-payment requirements and establish requirements for submission of a clean claim, but the bill was subsequently vetoed. Senate Bill 418 provides for the regulation and prompt payment of health care providers under certain health benefit plans and establishes penalties for violations of statutory provisions.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the Commissioner of Insurance in SECTION 1 (Article 3.70-2, Insurance Code), SECTION 3 (Article 3.70-3C, Insurance Code), SECTION 4 (Article 3.70-3C, Insurance Code), SECTION 7 (Section 843.336, Insurance Code), SECTION 8 (Section 843.337, Insurance Code), SECTION 10 (Section 843.3385, Insurance Code), SECTION 12 (Section 843.340, Insurance Code), SECTION 14 (Section 843.342, Insurance Code), SECTION 19 (Section 843.349, Insurance Code), SECTION 20 (Article 21.52Z, Insurance Code), and SECTION 21 of this bill.

ANALYSIS

Senate Bill 418 amends the Insurance Code to provide that a physician or provider must submit a claim to a PPO or HMO not later than the 95th day after the date services were provided, unless this time period is extended by contract. The bill specifies the authorized means for submitting a claim, the evidence that is considered proof of timely filing, and the procedures for determining when a claim is presumed to be received. The bill provides that a physician or provider who is noncompliant with claim filing provisions forfeits the right to payment except in the case of a catastrophic event. The bill prohibits the submission of a duplicate claim before the 46th day after the submission of the original claim and requires the Commissioner of Insurance (Commissioner) to adopt rules relating to duplicate claims. The bill deletes existing provisions relating to acknowledgment of receipt of a claim for medical or health care services.

The bill requires a PPO or HMO to determine whether a claim is payable not later than the 45th day after receiving a nonelectronic clean claim and not later than the 30th day after receiving an electronic clean claim, and to pay a portion of or the total amount of the claim or to provide notice of the reason why the claim will not be paid. The bill requires a PPO or HMO to pay an electronically submitted claim in full or to notify the pharmacy provider of the reasons for denying payment of a claim not later than the 21st day after the affirmative adjudication of the pharmacy claim. The bill deletes existing provisions relating to the

payment of a prescription benefit claim. The bill requires a PPO or HMO who intends to conduct an audit to pay submitted charges not later than the 30th day after receiving an electronic clean claim and not later than the 45th day after receiving a nonelectronic clean claim at 100%, rather than 85%, of the contracted rate. The bill provides that a PPO or HMO must complete an audit on or before the 180th day after the date the clean claim is received and requires any additional payments or refunds due to be made not later than the 30th day after the completion of the audit. The bill sets forth audit and appeals procedures. The bill deletes existing timeframes for the payment of refunds or additional payments following an audit.

The bill requires a PPO or HMO to request an attachment to a claim not later than the 30th day after receiving a clean claim, if additional information is needed to determine payment. The bill sets forth attachment procedures and the timeframe for determining whether a claim for which an attachment is requested is payable. The bill prohibits a PPO or HMO from withholding payment pending the receipt of an attachment and provides for refunds in the case of overpayment. The bill requires the Commissioner to adopt rules relating to attachments.

The bill requires that the claims payment processes of a PPO or HMO use certain codes, notes, and guidelines and be consistent with nationally recognized, noncommercial systems of bundling edits and logic, if available. The bill deletes copies of required data elements and claims formats from the information an HMO or PPO is required to provide to a physician or provider. The bill authorizes the recovery of court costs by a physician or provider in an action to recover payment. The bill deletes existing provisions relating to written notice of an addition or change in the data elements and to the application of prompt pay provisions to claims made by a preferred provider who is a member of the legislature.

The bill deletes the existing definition of a clean claim as a claim, as determined by department rules, that is submitted by a provider or physician for medical or health care services under a health benefit plan. The bill specifies the forms physicians or providers and institutional providers are to use for submitting nonelectronic and electronic claims, in order for a claim to be considered a clean claim. The bill authorizes the Commissioner to adopt rules relating to clean claims and prohibits the Commissioner from requiring any data element for an electronic claim that is not required in an electronic transaction by federal law. The bill authorizes the use of fewer data elements by contract and provides for the inclusion of additional fields, data elements, attachments, or other information.

The bill authorizes the recovery of an overpayment if a PPO or HMO provides written notice of the overpayment not later than the 180th day after receipt of the payment by the physician or provider and the physician or provider does not make arrangements for repayment on or before the 45th day after receiving the notice. The bill provides for appeals to requests for recovery of an overpayment.

The bill requires a PPO or HMO upon request for verification of a particular medical or health care service to inform a physician or provider without delay whether the service will be paid for if provided. The bill authorizes an HMO or PPO to establish a specific period during which the verification is valid of not less than 30 days. The bill specifies the times and days that an HMO or PPO is required to have personnel available to provide verification. The bill authorizes an HMO or PPO to decline to determine eligibility for payment, if the insurer provides notification of the reason the determination was not made. The bill requires an HMO or PPO that declines to provide verification to provide specific reasons for this decision. The bill prohibits an HMO or PPO from denying or reducing payment for services for which verification was received, if the services are provided on or before the 30th day after the date of verification, except in the case of misrepresented or unperformed services.

The bill requires a PPO to provide a list of services that require preauthorization and requires an HMO to provide a list of services that do not require preauthorization to a provider, as well as information concerning the process. The bill requires a PPO or HMO to determine whether services are medically necessary and appropriate, if payment for such services is conditioned on preauthorization. The bill specifies procedures for issuing a determination of whether services are preauthorized. The bill specifies the times and days that a PPO or HMO is required to have personnel available to provide preauthorization. The bill prohibits a PPO or HMO from denying or reducing payment based on the medical necessity or appropriateness of a preauthorized service, except in the case of misrepresented or unperformed services.

The bill authorizes an individual or group policy of accident and sickness insurance to contain a coordination of payment provision, in accordance with rules adopted by the Commissioner. The bill authorizes a PPO or HMO to require a physician or provider to retain information concerning other sources of payment and to provide this information to the HMO or PPO. The bill prohibits a PPO or HMO from requiring a physician or provider to investigate coordination of payment. The bill provides that coordination of payment does not extend the period for determining whether a claim is payable or for auditing a claim. The bill specifies procedures for submitting a claim that requires coordination between a primary and secondary payor and for the collection of an overpayment by a secondary payor.

The bill specifies the provisions that a contract between a PPO or HMO and a physician or provider must include relating to coding guidelines. The bill sets forth provisions relating to the use and disclosure of coding guideline and fee schedule information. The bill requires a PPO or HMO to provide certain information regarding bundling and unbundling software.

The bill sets forth penalties for HMOs or PPOs who do not make determinations regarding a claim and take actions based on these determinations within specified timeframes. The bill deletes existing provisions relating to penalties. The bill specifies the conditions under which an HMO or PPO is not liable for a penalty. The bill requires certain information regarding the payment of penalties on the explanation of payment statement. The bill provides for administrative penalties for certain violations that occur in processing more than two percent of clean claims. The bill deletes existing provisions relating to administrative penalties.

The bill establishes a technical advisory committee on claims processing and requires the committee to issue a report to the legislature on or before September 1 of even-numbered years. The bill requires the issuer of a health plan, as defined, to require by contract a licensed or registered health care professional or a licensed health facility to submit certain transactions electronically. The bill sets forth temporary provisions relating to the use of electronic transaction before the electronic transaction requirements take effect. The bill prohibits a health benefit plan from charging a fee for the adjudication of a claim. The bill authorizes the Commissioner to adopt rules to implement electronic health care transaction provisions.

The bill sets forth provisions relating to the application of certain provisions to entities contracting with HMOs or PPOs. The bill specifies the physicians and providers to whom prompt payment and verification provisions apply. The bill specifies the information that an identification card issued by a PPO or HMO must include. To the extent of any conflict between the Act and provisions relating to Uniform Claim Billing Forms, the Act controls. The bill prohibits provisions of the Act from being waived, voided, or nullified by contract, with certain exceptions. The bill requires the Commissioner to adopt the rules necessary to implement the Act not later than the 30th day after the effective date of the Act.

EFFECTIVE DATE

June 1, 2003 or, if the Act does not receive the necessary vote, the Act takes effect September 1, 2003.